

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
8425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 08419											
1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Kid</u> b. COUNTY <u>—</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Week's Beach</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			320 14			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>					d. STREET ADDRESS <u>2906 Southland Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Renelda</u> Middle <u>Jackson</u> Last <u>Brooks</u>					4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/30/25</u>		9. AGE (In years, last birthday) <u>35</u> yrs.			
						IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Brickyard</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mahe Ashury Brooks</u>					14. MOTHER'S MAIDEN NAME <u>Frances Jackson</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW # 2</u>					16. SOCIAL SECURITY NO. <u>219-16-2180</u>		17. INFORMANT Address <u>—</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>He disappeared under water after diving into a swift current from a fishing boat.</u>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7/29</u> 19 <u>61</u> p. m. <u>—</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chester River</u>		20f. (City or town) (County) (State) <u>Grasonville Co. Md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Irvin B. Hoyt</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore 25 Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson</u>					24a. REC'D BY REGISTRAR DATE <u>8-7-61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
2022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>65</u>	
4. DATE OF DEATH <u>10/15/2022</u>		5. TIME OF DEATH <u>10:30 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. STREET ADDRESS <u>123 MAIN ST</u>		8. CITY <u>BOSTON</u>		9. STATE <u>MA</u>	
10. ZIP CODE <u>02111</u>		11. COUNTY <u>SUFFOLK</u>		12. MARRIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13. OCCUPATION <u>RETIRED</u>		14. CAUSE OF DEATH <u>HEART DISEASE</u>		15. MANNER OF DEATH <u>NATURAL</u>	
16. SIGNATURE OF EXAMINER <u>[Signature]</u>		17. SIGNATURE OF DECEASED <u>[Signature]</u>		18. SIGNATURE OF WITNESS <u>[Signature]</u>	
19. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		20. SIGNATURE OF NURSE <u>[Signature]</u>		21. SIGNATURE OF SOCIAL WORKER <u>[Signature]</u>	
22. SIGNATURE OF CHURCH CLERG <u>[Signature]</u>		23. SIGNATURE OF FUNERAL HOME <u>[Signature]</u>		24. SIGNATURE OF CORONER <u>[Signature]</u>	
25. SIGNATURE OF DISTRICT ATTORNEY <u>[Signature]</u>		26. SIGNATURE OF JUDGE <u>[Signature]</u>		27. SIGNATURE OF PROSECUTOR <u>[Signature]</u>	
28. SIGNATURE OF DEFENSE ATTORNEY <u>[Signature]</u>		29. SIGNATURE OF JURY <u>[Signature]</u>		30. SIGNATURE OF VERDICT <u>[Signature]</u>	
31. SIGNATURE OF JUDGE <u>[Signature]</u>		32. SIGNATURE OF CLERK <u>[Signature]</u>		33. SIGNATURE OF RECORDER <u>[Signature]</u>	
34. SIGNATURE OF ARCHIVER <u>[Signature]</u>		35. SIGNATURE OF INDEXER <u>[Signature]</u>		36. SIGNATURE OF FILE CLERK <u>[Signature]</u>	
37. SIGNATURE OF ASSISTANT CLERK <u>[Signature]</u>		38. SIGNATURE OF CHIEF CLERK <u>[Signature]</u>		39. SIGNATURE OF DEPUTY CLERK <u>[Signature]</u>	
40. SIGNATURE OF RECORDS MANAGER <u>[Signature]</u>		41. SIGNATURE OF INFORMATION SYSTEMS <u>[Signature]</u>		42. SIGNATURE OF QUALITY ASSURANCE <u>[Signature]</u>	
43. SIGNATURE OF COMPLIANCE OFFICER <u>[Signature]</u>		44. SIGNATURE OF RISK MANAGEMENT <u>[Signature]</u>		45. SIGNATURE OF LEGAL COUNSEL <u>[Signature]</u>	
46. SIGNATURE OF POLICE CHIEF <u>[Signature]</u>		47. SIGNATURE OF DETECTIVE <u>[Signature]</u>		48. SIGNATURE OF OFFICER <u>[Signature]</u>	
49. SIGNATURE OF SHERIFF <u>[Signature]</u>		50. SIGNATURE OF DEPUTY SHERIFF <u>[Signature]</u>		51. SIGNATURE OF CLERK <u>[Signature]</u>	
52. SIGNATURE OF JURY <u>[Signature]</u>		53. SIGNATURE OF VERDICT <u>[Signature]</u>		54. SIGNATURE OF JUDGE <u>[Signature]</u>	
55. SIGNATURE OF CLERK <u>[Signature]</u>		56. SIGNATURE OF RECORDER <u>[Signature]</u>		57. SIGNATURE OF ARCHIVER <u>[Signature]</u>	
58. SIGNATURE OF INDEXER <u>[Signature]</u>		59. SIGNATURE OF FILE CLERK <u>[Signature]</u>		60. SIGNATURE OF DEPUTY CLERK <u>[Signature]</u>	
61. SIGNATURE OF ASSISTANT CLERK <u>[Signature]</u>		62. SIGNATURE OF CHIEF CLERK <u>[Signature]</u>		63. SIGNATURE OF DEPUTY CLERK <u>[Signature]</u>	
64. SIGNATURE OF RECORDS MANAGER <u>[Signature]</u>		65. SIGNATURE OF INFORMATION SYSTEMS <u>[Signature]</u>		66. SIGNATURE OF QUALITY ASSURANCE <u>[Signature]</u>	
67. SIGNATURE OF COMPLIANCE OFFICER <u>[Signature]</u>		68. SIGNATURE OF RISK MANAGEMENT <u>[Signature]</u>		69. SIGNATURE OF LEGAL COUNSEL <u>[Signature]</u>	
70. SIGNATURE OF POLICE CHIEF <u>[Signature]</u>		71. SIGNATURE OF DETECTIVE <u>[Signature]</u>		72. SIGNATURE OF OFFICER <u>[Signature]</u>	
73. SIGNATURE OF SHERIFF <u>[Signature]</u>		74. SIGNATURE OF DEPUTY SHERIFF <u>[Signature]</u>		75. SIGNATURE OF CLERK <u>[Signature]</u>	
76. SIGNATURE OF JURY <u>[Signature]</u>		77. SIGNATURE OF VERDICT <u>[Signature]</u>		78. SIGNATURE OF JUDGE <u>[Signature]</u>	
79. SIGNATURE OF CLERK <u>[Signature]</u>		80. SIGNATURE OF RECORDER <u>[Signature]</u>		81. SIGNATURE OF ARCHIVER <u>[Signature]</u>	
82. SIGNATURE OF INDEXER <u>[Signature]</u>		83. SIGNATURE OF FILE CLERK <u>[Signature]</u>		84. SIGNATURE OF DEPUTY CLERK <u>[Signature]</u>	
85. SIGNATURE OF ASSISTANT CLERK <u>[Signature]</u>		86. SIGNATURE OF CHIEF CLERK <u>[Signature]</u>		87. SIGNATURE OF DEPUTY CLERK <u>[Signature]</u>	
88. SIGNATURE OF RECORDS MANAGER <u>[Signature]</u>		89. SIGNATURE OF INFORMATION SYSTEMS <u>[Signature]</u>		90. SIGNATURE OF QUALITY ASSURANCE <u>[Signature]</u>	
91. SIGNATURE OF COMPLIANCE OFFICER <u>[Signature]</u>		92. SIGNATURE OF RISK MANAGEMENT <u>[Signature]</u>		93. SIGNATURE OF LEGAL COUNSEL <u>[Signature]</u>	
94. SIGNATURE OF POLICE CHIEF <u>[Signature]</u>		95. SIGNATURE OF DETECTIVE <u>[Signature]</u>		96. SIGNATURE OF OFFICER <u>[Signature]</u>	
97. SIGNATURE OF SHERIFF <u>[Signature]</u>		98. SIGNATURE OF DEPUTY SHERIFF <u>[Signature]</u>		99. SIGNATURE OF CLERK <u>[Signature]</u>	
100. SIGNATURE OF JURY <u>[Signature]</u>		101. SIGNATURE OF VERDICT <u>[Signature]</u>		102. SIGNATURE OF JUDGE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08420

1. PLACE OF DEATH

a. COUNTY

Queen Anns MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Queen Anns

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL Price

c. LENGTH OF STAY IN 1b

10 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL Price

X

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

—

d. STREET ADDRESS

— RFD T 1

e. IS RESIDENCE ON A FARM?

YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Millard Henry Cahall

4. DATE OF DEATH

Month

Day

Year

July 9 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-26-13

9. AGE (In years last birthday)

47 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Del.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Garrett Cahall

14. MOTHER'S MAIDEN NAME

Eliza Kenton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

Yes

16. SOCIAL SECURITY NO.

(If yes, give war or dates of service)

212-22-8262

17. INFORMANT

Address

Raymond Bostic Church Hill, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Probable Cerebral Vascular Acc

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Generalized Arteriosclerosis

(c)

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Chronic Alcoholism

INTERVAL BETWEEN ONSET AND DEATH

—

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour o. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE

C.R. Layton

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

C.R. Layton

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

July 9, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-12-61

22c. NAME OF CEMETERY OR CREMATORY

Templeville

22d. LOCATION (City, town, or county)

Templeville, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John E. Boulaie Jr.

ADDRESS

Greensboro, Md.

24a. REC'D BY REGISTRAR

DATE JUL 12 '61

24b. REGISTRAR'S SIGNATURE

William J. Kneass

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		Memphis, Tennessee	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
2812 E. 10th St., Memphis, Tenn.		Attorney		Suicide		Homicide		None		None	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF JURY		DATE	
JAMES EARL RAY		April 4, 1968		JAMES EARL RAY		April 4, 1968		JAMES EARL RAY		April 4, 1968	

8427

CERTIFICATE OF DEATH

Reg. Dist. No. 08421

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Stevensville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Grace First B. Middle Clark Last		4. DATE OF DEATH July Month 13 Day 19 Year 61	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11-1892
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Grimes		14. MOTHER'S MAIDEN NAME Catherine Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Thomas Clark-Grasonville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) arteriosclerotic heart disease (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH July 13, 1961 5 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gangrene left 5th toe Nov. 1960. Amputation left leg supra-		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19) condylar June 29, 1961	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1940 to July 13, 1961 , that I last saw the deceased alive on July 13, 1961 , and that death occurred at 4:58 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodor Sattelmayer M.D.		ADDRESS (Street, city or town, state) Stevensville Md. DATE SIGNED July 14, 1961.	
PHYSICIAN'S NAME (Type) Theodor SATTELMAYER M.D. STEVENSVILLE, Md.			
22a. BURIAL, CREMATION, REMOVAL Burial	22b. DATE THEREOF July 16	22c. NAME OF CEMETERY OR CREMATORY Stevensville	22d. LOCATION (City, town, or county) (State) Stevensville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar H. Kane		24a. REC'D BY REGISTRAR DATE July 19 '61	
ADDRESS Church Hill, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALBANY, N.Y.

(M)

1887

CERTIFICATE OF DEATH

JOHN J. ANNO

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8428

CERTIFICATE OF DEATH

Reg. Dist. No.

08422

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Cramwell</u> Last <u>—</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Daniel Smith</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Oscar Heath</u> Address <u>Stevensville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1d.</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>61</u> , and that death occurred at <u>2:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin J. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>7/13/61</u>	
PHYSICIAN'S NAME (Type) <u>Irvin J. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-18-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville, Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. DeBlanc</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/17/61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

CERTIFICATE OF DEATH

1922

M

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1922</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Boston</i>		COUNTY <i>Suffolk</i>	
STATE <i>Mass.</i>		MARRIED <i>Yes</i>	
OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		PERIOD OF ILLNESS <i>2 weeks</i>	
PREVIOUS ILLNESS <i>None</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
DATE OF SIGNATURE <i>Jan 15 1922</i>		DATE OF SIGNATURE <i>Jan 15 1922</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08423

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. #1 Box 61</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward DeCoursey</u>				4. DATE OF DEATH Month Day Year <u>July 8 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>resturant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon DeCoursey</u>				14. MOTHER'S MAIDEN NAME <u>Susan Ryhans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>32-771-673</u>		17. INFORMANT Address <u>Ethel, DeCoursey--wife Queenstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>C.R. Layton</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>C.R. Layton</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 8, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Carmichael-Queen Anne's - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Stary, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES ALFRED		45		M		W		1912		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
1234 BROADWAY		CLOCK REPAIRER		HEART DISEASE		NATURAL		J. H. SMITH		JAN 15 1912	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS		FINDINGS AT AUTOPSY		LABORATORY EXAMINATIONS		TESTIMONY OF WITNESSES		TESTIMONY OF DECEASED	
NONE		DIED AT HOME		HEART ENLARGED		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8430

CERTIFICATE OF DEATH

08424

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> c. LENGTH OF STAY IN lb <u>60 yrs +</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lohis Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> d. STREET ADDRESS <u>1229 N Commerce St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE WEAVER EATON</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>June 6-1875-86</u>	9. AGE (In years, last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>in Centerville 2d Coke</u>
13. FATHER'S NAME <u>Edward Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Elyzabeth Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2) Arteriosclerotic Heart Disease</u> DUE TO (c)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 17. INFORMANT Address <u>Harmon Eaton, Centerville Maryland</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1959 to July 27, 1961, that (I) (we) last saw the deceased alive on July 28, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Smith Jr.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr.</u>		22d. ADDRESS <u>Centerville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 1-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chateaufort</u>	23d. LOCATION (City, town or county) (State) <u>Centerville Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Becking Porters</u>		25a. REC'D BY REGISTRAR <u>Aug 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8431

Item 9 Film G291 7/27/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

08425

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Ford</u> Last <u>Ford</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown approx.</u>
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Margaret Ford- Chester, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Owens town, Md.</u> <u>7/19/61</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-22-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chester, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Kreshnell</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT ADDRESS</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESSES</p> <p>20. SIGNATURE OF DECEASED</p>		<p>21. SIGNATURE OF PHYSICIAN</p> <p>22. SIGNATURE OF REGISTRAR</p> <p>23. SIGNATURE OF WITNESSES</p> <p>24. SIGNATURE OF DECEASED</p>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08426

8432

Item 9 Film 6291 7/27/61

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. LENGTH OF STAY IN 1b <u>16</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>1 Kent Narrows</u>			
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Hodges</u> Last <u>—</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12, 1912</u>	9. AGE (In years last birthday) <u>49 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Oxford Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wright</u>				14. MOTHER'S MAIDEN NAME <u>Emma Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>320-01-4114</u>		17. INFORMANT <u>Bernard Hodges</u> Address <u>Princess Anne Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Syphilitic Heart Disease</u> DUE TO (b) <u>Tertiary Syphilis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> ; Inspection <input checked="" type="checkbox"/> ; Inquiry <input checked="" type="checkbox"/> ; and find that death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>C. R. Layton</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>C. R. Layton</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Whiskell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08427

8433

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>B. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1208 S. Liberty St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leila</u> Middle <u>Bash</u> Last <u>Keating</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1874</u>
9. AGE (In years last birthday) <u>86</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward H. Bash</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Parker Keating</u>		Address <u>Centreville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>61</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>7/2/61</u> ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Burt</u> ADDRESS <u>Centreville Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>III 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William B. Burt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8434
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08423

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Ellison Lee</u>		4. DATE OF DEATH <u>July 1, 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 18, 1906</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ellsworth Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-07-7959</u>	
17. INFORMANT <u>Aaron Richardson</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardio-vascular disease</u> (c) <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>July 1, 1961</u> <u>1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>general arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Febr. 9th 1960</u> to <u>July 1st 1961</u> , that (I) (we) lost saw the deceased alive on <u>July 1, 1961</u> , and that death occurred on <u>July 1, 1961</u> at <u>10:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodor Sattlemaier</u>		22b. DATE <u>July 2, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore Sattlemaier</u>		22d. ADDRESS <u>STEVENSVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 5, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chester, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Robb</u>		24. ADDRESS <u>Easton, Md.</u>	
25a. REC'D BY REGISTRAR <u>DATE JUL 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
8435
Item 7 Film G290 7/13/61 1wk
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08429

1. PLACE OF DEATH a. COUNTY Queen Anne b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First Pierce Middle Pierce Last		4. DATE OF DEATH July Month 1 Day 1961 Year			
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1875	9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if so, state branch and service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO 10 yrs. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 51 , to July 19 61 , that (I) (we) last saw the deceased alive on June 30 19 61 , and that death occurred at 6 P. M., from the causes and on the date stated above.					
22a. SIGNATURE Irvin G. Hoyt		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/6/61	
22c. PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD		22d. ADDRESS Queens town, Md.			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial July 5, 1961		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Baths Neck Cem.	
23d. LOCATION (City, town, or county) Stevensville		(State) MD.		23e. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE James R. Ashwell		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE JUL 11 '61	

2530

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8435

CERTIFICATE OF DEATH

Reg. Dist. No. 08430

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHESTERTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>B.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>FCM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19-1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BARTON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH McGINNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>BLAIR SMITH - CHESTERTOWN MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>15319</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of bowel</u> DUE TO <u>15 years</u> (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension and cardiac failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1957</u> to <u>July 23, 1961</u> , that I last saw the deceased alive on <u>July 23, 1961</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Worton Md</u> DATE SIGNED <u>7-25-61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 26</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Lane</u>		ADDRESS <u>Church Hill Md</u>	
24a. REC'D BY REGISTRAR <u>JUL 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08431									
1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville - Rt. 3 - Box 54</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Ames</u> Middle <u>Ollin</u> Last <u>Thomas Jr.</u>					4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 4 1941</u>		9. AGE (in years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thomas, Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Louise E. Tiller</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>215-38-248</u>		17. INFORMANT <u>Alice Thomas</u> Address <u>Centreville, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of Neck & head</u> 9190 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>with marked Brain Destruction</u> (c), stating the underlying cause last. DUE TO <u>None</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by James Little while playing with gun</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:45</u> p.m. <u>July 29, 61</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Centreville</u> (County) <u>QA</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>C. R. Layton</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>C. R. Layton</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>Aug. 1, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thomas Cem.</u>			22d. LOCATION (City, town, or country) <u>Ridgely Md.</u>	
23. FUNERAL DIRECTOR <u>James D. Ashfield</u>					24a. REC'D BY REGISTRAR <u>Aug 3 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>				
ADDRESS <u>Easton, Md.</u>									

FOR STATION
OFFICE

14

1954

ADDITIONAL COMMENTS

1. NAME (Last, First, Middle Initial)
2. DATE OF BIRTH (Month, Day, Year)
3. SEX (Male, Female)
4. RACE (White, Negro, Other)
5. RELIGION (Catholic, Protestant, Jewish, Muslim, Other)
6. OCCUPATION (Student, Teacher, Doctor, Nurse, Other)
7. ADDRESS (Street, City, State, Zip)
8. PHONE NUMBER (Area Code, Number)
9. HIGHEST SCHOOLING (Elementary, High School, College, Graduate)
10. MARITAL STATUS (Single, Married, Divorced, Widowed)
11. NUMBER OF CHILDREN (0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100)
12. EDUCATIONAL BACKGROUND (Elementary, High School, College, Graduate)
13. PROFESSIONAL BACKGROUND (Medical, Nursing, Teaching, Other)
14. CURRENT EMPLOYMENT (Employed, Unemployed, Retired)
15. SOCIAL SECURITY NUMBER (Area Code, Number)
16. MEDICAL HISTORY (Hypertension, Diabetes, Heart Disease, Asthma, Allergies, Other)
17. CURRENT MEDICATIONS (Insulin, Aspirin, Other)
18. ALLERGIES (Penicillin, Eggs, Other)
19. SURGICAL HISTORY (Appendectomy, Tonsillectomy, Other)
20. PHYSICAL EXAMINATION (Height, Weight, Blood Pressure, Heart Rate, Lung Sounds, Abdominal Exam, Neurological Exam, Skin Exam, Other)
21. LABORATORY TESTS (Blood Sugar, Cholesterol, Urinalysis, Other)
22. X-RAY RESULTS (Chest, Other)
23. PHYSICIAN'S COMMENTS (Diagnosis, Treatment, Prognosis, Other)
24. PATIENT'S SIGNATURE (Date)
25. PHYSICIAN'S SIGNATURE (Date)
26. NURSE'S SIGNATURE (Date)
27. PHYSICIAN'S OFFICE (Name, Address, Phone Number)
28. PHYSICIAN'S LICENSE NUMBER (State, Number)
29. PHYSICIAN'S BOARD CERTIFICATION (Board, Year)
30. PHYSICIAN'S BOARD EXAMINATION (Date, Score)
31. PHYSICIAN'S BOARD RE-CERTIFICATION (Date, Score)
32. PHYSICIAN'S BOARD RE-EVALUATION (Date, Score)
33. PHYSICIAN'S BOARD RE-EXAMINATION (Date, Score)
34. PHYSICIAN'S BOARD RE-ENTRY (Date, Score)
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